BADGERCARE PREMIUM EMPLOYER WAGE WITHHOLDING INFORMATION AND INSTRUCTIONS

The Wisconsin BadgerCare program requires information to enable BadgerCare to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information shall include but is not limited to information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to the Medicaid program administration such as payment of premiums by recipients. Failure to supply the information requested by the form may result in denial of Medicaid payment for services.

INSTRUCTIONS:

BadgerCare Recipients
The employer should fill out this form for the BadgerCare premium payment to be taken out of the paycheck. If this option is chosen, fill in the BadgerCare Case Number found on the BadgerCare premium notice. Give the Employer Wage Withholding Form, along with the Electronic Funds Transfer (EFT) form, to the employer. The employer can also call 1-888-907-4455 to request that the forms be mailed to the them.

Employer Instructions for Completing This Form
Fill out the employee's last and first name, Social Security Number, and monthly BadgerCare premium amount.

BadgerCare premiums may be paid either by EFT or by direct payment.

- **Electronic Funds Transfer**
  If the employer chooses to pay by EFT, complete the Recipient/Employer Electronic Funds Transfer form. Send the form to the address listed at the bottom of the EFT form. BadgerCare will then take the entire premium amount out of the checking account once per month.

  The form can also be faxed to 1-608-251-1513.

- **Direct Payment**
  Employers will receive a premium notice each month if they choose to make a direct payment each month. Send the payment with the premium notice and completed Employer Wage Withholding form to:

  BadgerCare
  c/o Wisconsin Department of Health and Family Services
  PO Box 93187
  Milwaukee WI 53293-0187

  Then send the completed Employer Wage Withholding form to:

  BadgerCare Cash/Premium Unit
  PO Box 6648
  Madison WI 53716-0648

- **Employer Information**
  Fill out employer's name and address.

If there any questions regarding the above information, call 1-888-907-4455.

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 13025 (Rev. 04/02)

STATE OF WISCONSIN

BADGERCARE PREMIUM
EMPLOYER WAGE WITHHOLDING

INSTRUCTIONS: Type or print clearly. Before completing this form, read the information and instructions on the reverse side of this form. Complete this form for the employee (and Electronic Funds Transfer (EFT) form, if applicable). If there are any questions, call 1-888-907-4455.

Employee Information

Name — Employee (Last, First, Middle Initial)	Medicaid ID Number of Case Head Enrolled in MAPP
Social Security Number — Employee	Monthly Premium Amount

Electronic Funds Transfer
To pay the premium via monthly EFT, complete the Recipient / Employer EFT form. The form can be faxed to 1-608-221-8185.

Direct Payment
To pay the premium via direct payment, send the payment, payable to BadgerCare, and this completed form to the address listed below. Do not send cash.

Employer Information

Name — Employer	Telephone Number	
Address — Employer		
City	State	Zip Code
SIGNATURE — Employer		Date Signed

DISTRIBUTION: Mail completed form along with direct payment to:

BadgerCare
c/o Wisconsin Department of Health and Family Services
PO Box 93187
Milwaukee WI 53293-0187

Reset Form